Creekside Dentistry
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DENTAL HISTORY FORM

Patient Name				
What is the reason for your visit?				
Date of last dental visit	Date of last dental cleaning	Last full mouth x-rays		
What was done at your last dental visit?				
Previous dentist name		Previous dentist phone number		
Previous dentist address		City	State	Zip Code
How often do you have dental exams?				
What is your regime for caring for your mouth?				
Do you have any current dental concerns? If yes, please describe: No ◯ Yes ◯				

Teeth sensitivity:			**Prior care/conditions**: Have you ever had?		
Acute hot/cold?	Y ◯	N ◯	Orthodontics?	Y ◯	N ◯
Sweets	Y ◯	N ◯	Oral Surgery?	Y ◯	N ◯
Biting/chewing	Y ◯	N ◯	Gum Surgery?	Y ◯	N ◯
Food caught between, where?	Y ◯	N ◯	Bite adjusted?	Y ◯	N ◯
Gums:			Wear a nightguard?	Y ◯	N ◯
Bad odor or tastes	Y ◯	N ◯	Serious injury to mouth or head?	Y ◯	N ◯
Bleed or hurt	Y ◯	N ◯	Clicking or popping of the jaw?	Y ◯	N ◯
Parents lost teeth to gum disease	Y ◯	N ◯	Difficulty opening or closing?	Y ◯	N ◯
Habits:			Difficulty chewing on one side?	Y ◯	N ◯
Clench or grind daytime/nighttime?	Y ◯	N ◯	Headache, shoulder ache or neck problems?	Y ◯	N ◯
Have tired jaws in the morning?	Y ◯	N ◯			
Bite your lips or cheeks regularly	Y ◯	N ◯	**Smile:**		
Hold pencils, nails, fingernails with your teeth?	Y ◯	N ◯	Are you satisfied with your smile?	Y ◯	N ◯
Mouth breath, snore or have a sleeping disorder?	Y ◯	N ◯	Would you like to keep all your teeth all of your life?	Y ◯	N ◯
Smoke or chew tobacco?	Y ◯	N ◯	**Anxiety:**		
Medications:			Are you nervous about dental treatment? If so, what is your biggest concern?	Y ◯	N ◯
Do you require premedication before dental care?	Y ◯	N ◯			

Other:
Have you had an upsetting dental experience? Y ◯ N ◯
If so please describe:

Is there anything else you would like us to know?